Malhotra Care Homes Limited

Addison Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 1 and 5 December 2016 and 26 January 2017. We last inspected the service in June 2016. This had been a focused inspection following up on previous inspection in October and November 2015. In June 2016 we found two breaches of the regulations, specifically Regulation 12, safe care and treatment, and Regulation 17, good governance.

Addison Court is registered to provide accommodation for up to 70 people who need nursing and personal care. It provides a service primarily for older people, including people with dementia. It is owned and operated by the provider Malhotra Care Homes Limited. At the time of our inspection there were 53 people accommodated there.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Where people were not able to make important decisions about their lives the principles of the Mental Capacity Act 2005 were followed and applications made to appropriately deprive people of their liberty were made. However DoLs were not always correctly implemented. We made a recommendation about this.

As part of their recruitment process the service carried out background checks on new staff. Staff were aware of how to identify and report abuse. There were policies in place that outlined what to do if staff had concerns about the practice of a colleague.

Care plans were person centred and showed that individual preferences were taken into account. Care plans were subject to regular review to ensure they met people's changing needs. They were easy to read and based on assessment and reflected the needs of people. Risk assessments were carried out and plans were put in place to reduce risks to people' safety and welfare. Though people were involved in information gathering about their preferences they were not always involved in the final stages of care planning, we made a recommendation about this.

People who used the service told us that they liked the people who supported them and thought the majority were caring and polite.

Staff had received training to support them to deliver care safely and effectively. The registered manager had identified areas for development in the overall training of staff and was sourcing appropriate training. The manger was also making improvements around supervision and appraisal.

People were supported to maintain their health and to access health services if needed.

People who required support with eating and drinking received it and had their nutrition and hydration support needs regularly assessed. However the service did not always communicate about people's nutritional needs effectively. We made a recommendation about this.

Staff had developed caring relationships with people and communicated in a kind and professional manner. They were aware of how to treat people with dignity and respect. Policies were in place that outlined acceptable standards in this area.

There was a complaints procedure in place that outlined how to make a complaint and how long it would take to deal with. People were aware of how to raise a complaint and who to speak to about any concerns they had.

The service regularly sent questionnaires to people who used the service and their relatives to ascertain they were satisfied with the service. The registered manager had a clear vision for the future of the service.

The service did not manage medicines appropriately. They were not correctly stored, monitored or signed for correctly when administered. Clinical rooms and medication trolleys were disorganised and unclean.

Though equipment in the home was clean and well maintained some pressure mattresses had not been set properly according to people's weight. Changes were made during the course of our inspection to rectify these issues.

There was a malodour in some areas of the home. The registered provider agreed that this was not acceptable and began reviewing potential solutions immediately. We made a recommendation about this.

We found a breach of the Regulations in relation to safe care. You can see what action we have asked the provider to take in relation to this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not managed correctly.

At the time of our inspection there were sufficient staff to meet people's needs.

There was a malodour in parts of the home.

Is the service effective?

Good

The service was effective.

Staff were subject to ongoing development to ensure they had the skills and knowledge to provide the care people required.

The service worked in conjunction with other health and social care providers to try to ensure good outcomes for people who used the service.

People received adequate support with nutrition and hydration.

Is the service caring?

Good

The service was caring.

People told us they felt they were properly cared for.

People were not always involved in all aspects of the planning of their care.

There were policies and procedures in place to ensure people were not discriminated against.

Is the service responsive?

Good

The service was responsive.

People enjoyed a range of activities.

People and their relatives knew how to raise concerns. There was a policy in place outlining how complaints should be dealt with.

Care plans were concise and reflected people's needs accurately.

Is the service well-led?

Good

The service was well-led.

The service had a quality assurance system in place.

The registered manager had a vision for the future of the service.

People were asked for their views about the service.

Addison Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 1 and 5 December 2016 and the 26 January 2017. The first and third day were unannounced.

The inspection was carried out by one adult social care inspection manager, three adult social care inspectors and a pharmacist inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. In addition we spoke with representatives from adult social care. We planned the inspection using this information.

We spoke with five of the people who used the service, two relatives and twenty members of staff including the manager, the registered provider, the senior management team, nurses, care staff and auxiliary staff.

We read 19 written records of care and other policies and records that related to the service. We looked at 3 staff files which included supervision, appraisal and induction and examined the training records and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

We spoke with people and asked if they were happy with the way their medicines were administered. One person told us, "They come round with your medicines, I've no complaints whatsoever." Other people told us they were not confident about the way the service managed medicines.

At our last two inspections in October 2015 and in June 2016 breaches of legal requirements were found. These included a failure to ensure suitable arrangements for the safe care and treatment of people using the service. At that time we found gaps in recording the administration of topical medicines (creams applied to the skin) which meant we could not be sure they were administered as prescribed. We found there were lengthy gaps in administration records, administration instructions were unclear, as were guidelines in people's care plans. We reviewed the action plan the provider sent to us following the inspection. This included details of how they planned to comply with legal requirements.

We looked at the systems in place for medicines management. We assessed 12 medication administration records (MARs) and looked at medicines storage, handling and stock requirements. We spoke with two nurses, and the manager for the home. We found that appropriate arrangements for the safe handling of medicines were not always in place.

We observed that medicines were stored in treatment rooms on two floors and the keys were held by the nurse's on duty. On the ground floor, room and medicines fridge temperatures were not recorded daily and when recorded only current fridge temperatures were documented. This was not in line with national guidance or the home's policy. On the second floor the nurse on duty could not find the record of medicines fridge or room temperatures. The treatment rooms were not part of the cleaning schedule and we found empty medicines pots on the floor under the counter on the ground floor. The treatment rooms were cluttered and medicines awaiting destruction were stored in boxes next to medicines received for the current administration cycle. Trolleys were used to store medicines when completing the medicines round and separate compartments were labelled for each residents medicines; however we found that multiple medicines were not in the correct area which increased the risk of residents receiving the incorrect medicines. In addition tea time and night time medicines trays were stored outside of the trolley as there was not enough room for them to be locked away due to the trolley being over stocked. Again this increased the risk of residents receiving incorrect medication. On the third day of our inspection we saw that some improvements had been made to the ground floor clinical room. It was tidier and the registered manager was waiting for some new cupboards and shelving to be provided. The middle floor clinical room remained in a poor state of tidiness.

Controlled drugs were stored securely and the key held by an appropriate person. Nursing staff kept accurate records of administration however no regular controlled drug stock checks had been completed on either floor of the nursing home.

The majority of MAR charts were printed by the community pharmacy. Where handwritten entries were made, two nurses did not always sign them, which was not a safe practice in line with National Institute of

Care Excellence (NICE) and Nursing and Midwifery Council (NMC) guidance, or the providers own policy.

We checked the processes in place for stock balance and ordering of medicines. The ordering system used at the home was described to us by staff. However, we found that duplicate orders had been placed for one person as their medicines could not be located and for a second person we could not locate one regular anxiety medicine. This medicine intended for current use was subsequently found by the nurse on duty in the returns box awaiting destruction. Carried forward balances, which are used at the start of the medicines cycle to ensure consistent records of stock levels, were not always completed accurately. This meant that the service may have not been aware of when stock levels of medicines were low which in turn may have led to them running out of important medicines.

Administration signatures on the MAR charts did not always match with the quantities of boxed and bottled medications in the trolleys. Missed doses were not always coded for on the MAR and the reasons for not administering were not recorded. When 'as required' medicines were given these were not always recorded on the back of the MAR as per the home's policy. This meant staff were unaware of why they had been administered and if they had been effective. Medicines which were prescribed with a variable dose did not always have the dose recorded so staff could not be sure of the total quantity administered and stock controls were not robust. This increased the risk of people receiving an overdose and meant records did not accurately reflect the treatment people had received.

A system was in place to ensure that medicines prescribed at 7am or before breakfast were administered by night staff. However on the day of our visit the medicines round had not occurred at breakfast time and one person who took Parkinson's disease medicines at 8am did not receive their morning dose until 10.20am. This particular type of medicine must be given at the correct time for it to be fully affective.

Topical medicines were not always administered as prescribed. A cream application record was used by care staff to record administration, however the charts were not clear as to which cream they were for or what area they were to be applied to. For one resident the records for the administration stated, 'Zerocream apply two to three times daily'. However this had been changed to a different preparation in September, but this new item was not listed on the MAR and the frequency of application was not documented. Between the period of 25 September 2016 and our visit on 30 November 2016 the new preparation had been applied on 26 occasions which was not consistent with once daily administration. We spoke with the resident who stated their skin was very dry and they were waiting for a review from the doctor. The nurse confirmed that a review was scheduled but could not confirm if the creams had been administered or what the frequency was meant to be. A second resident had three topical creams prescribed as soap substitutes or 'as directed'. Care staff stated they were used daily however the record for Mediderma s stated this had not been applied on 16 occasions in November 2016 and the last recorded date for Zerobase cream was 1 September 2016. This demonstrated that creams were not always being applied as prescribed.

We reviewed records for administration of transdermal patches and found that although the patches had been signed as administered at the correct frequency, no patch application charts were in place for both residents we reviewed. Failure to record application site rotation increases the risk of skin sensitisation and irritation.

We reviewed three care plans specifically for medicines. We found that the care plans were not up to date or reviewed at the appropriate frequency. For example one resident's last review had taken place in July 2016. However changes had occurred after this date and these were not recorded. We looked at a residents risk management plan for thickened fluids and found this lacked detail regarding dosages or fluid consistency to ensure safe treatment.

We looked at the systems in place for covert administration. The home had specific documentation for covert administration, however this was not located in the files we reviewed. Risk assessments were not specific to which medicines could be given covertly and no advice had been documented regarding the appropriateness of the medicines for covert administration. We were shown two people's 'best interest' documentation in respect of covert medicines administration from March and October 2015 respectively, which had not had a review at the specified six monthly interval since that time. This meant the continued administration of medicines by covert means could have been open to legal challenge.

We looked at medication audits carried out by the home. An audit from August 2016 had found shortfalls and had actions signed as completed. However a subsequent audit in November 2016 found an increase in non-compliance, which was in line with our findings. Actions were recorded, however no dates for completion had been set or designated person specified who was responsible for overseeing the action. We asked one staff nurse if they were aware of the recent medicines audit and subsequent action plan and they said they were not.

During the third day of our inspection the provider had continued with plans to roll out an electronic medicines management system. The provider believed that the new system would reduce errors and help keep people safe. The registered manager was ensuring that this was done in a safe manner as she wished to ensure that all staff were confident and competent in its use.

These findings represented a continued breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Equipment in the home was well maintained and checked regularly by a qualified engineer. This included lifting equipment and the passenger lift. During the first day of our inspection we checked the settings of pressure relieving mattresses. Pressure relieving mattresses are a specialist piece of equipment and can greatly reduce the risk of pressure ulcers, also known as bed sores. For optimum effectiveness the mattresses should be set according to an individual's weight. Staff had not set the mattresses correctly. However on the third day of our inspection we saw this issue had been rectified.

Addison Court was decorated to a high standard with hotel style accommodation for the people who lived there. One person told us, "The laundry do a wonderful job, excellent. The rooms are kept very clean." The home was clean and we noted domestic staff working hard throughout the inspection. At times we did detect a malodorous smell, particularly within the unit that cared for people who lived with dementia. We spoke with the registered provider about this issue. On checking our findings the registered provider's senior management team agreed that there was an issue and discussed ways reduce and eliminate odours.

We recommended that the registered provider continues to review and improve the way odours are managed in the home.

People's written records of care held important information for staff about risks and the actions to take to minimise or eliminate them. For example some people were identified as being at risk of becoming agitated or frustrated, particularly if they were living with dementia. The service had plans in place to help people relax or to distract them from the source of their upset. This helped prevent people from 'lashing out' at others or hurting themselves.

During our inspection we saw there was sufficient staff on duty to meet people's needs. We observed staff carrying out their duties professionally and efficiently. People did not have to wait an unreasonable amount of time for support or assistance. We spoke with staff who told us they felt that on some days there was

more staff on duty than others and sometimes they were, 'short staffed'. We spoke with the manager, the registered provider and the senior management team about this. They told us that a review was underway of the rota and staff shift patterns. In the meantime they were using agency staff or staff from the provider's other homes to ensure there was adequate staffing. The rotas we saw confirmed this. In addition they were using a dependency tool to help them decide on staffing levels. We will continue to monitor staffing levels at Addison Court to ensure that they maintain safe staffing levels.

Staff we spoke with knew how to protect people who used the service from bullying, harassment and avoidable harm. Staff told us that they had received training that ensured they had the correct knowledge to be able to protect vulnerable people. The training records we saw confirmed this. If staff were concerned about the actions of a colleague there was a whistleblowing policy which provided clear guidance as to how to express concerns. This meant that staff could quickly and confidentially raise any issues about the practice of others if necessary.

Providers of health and social care services are required to tell us of any allegations of abuse. The manager of the service had informed us promptly of all allegations and other incidents as required. From these we saw, where staff had concerns about a person's safety the manager had taken appropriate action.

Staff had access to protective clothing such as gloves and aprons while carrying out personal care. Staff told us that infection control was part of their induction training and was regularly updated. This helped to ensure that people were cared for by staff who followed appropriate infection control procedures.

There were contingency plans in place to deal with emergency situations such as fire or power cuts. For example the home kept an accessible supply of torches and batteries should they be required. The registered manager or a senior member of staff was always available to talk to out of hours via telephone and would attend the home if necessary.

We looked at the recruitment records for three staff members. All new staff obtained a Disclosure and Barring Service (DBS) disclosure to check they were not barred from working with vulnerable people. The registered provider had obtained evidence of their good character and conduct in previous employment. All DBS checks and references were scrutinised to ensure they were in order and factually accurate.

Good

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and asked them if they felt staff were able to provide appropriate support. One relative told us, "Most of the staff have worked in care for over 20 years." They added, "The majority are fantastic."

Staff told us that they had received induction training before working in the home. They said they worked with experienced staff to gain knowledge about how to support people before working on their own. Where people had complex needs we saw that the staff who supported them had received specialist training in how to provide their care, for example caring for people with diabetes. However staff who were caring for people who lived with dementia told us they had not received training in how to safely disengage from people who were, due to their illness, showing signs of aggression. We spoke with the registered provider and the manager about this and they agreed to develop their training programme to ensure staff were properly skilled in this area. On the third day of our inspection the registered manager was able to confirm this training was about to be delivered to staff.

The registered manager and the registered provider had systems in place to record the training that care staff had completed and to identify when training needed to be repeated. As well as training the provider deemed mandatory additional training was available, for example vocational qualifications. Staff we spoke with confirmed they had completed training courses, this was reflected in their personnel files.

The registered manager had identified that supervisions and appraisals were not up to date in accordance with the provider's policy. Supervision sessions give staff the opportunity to discuss training required or requested and their performance within their roles. The registered manager had a plan in place to bring all supervision and appraisals up to date and was making good progress. We will continue to monitor this.

We asked people if they enjoyed the food in the home. One person commented, "The meals are very good. I get enough, too much sometimes. They do tend to spoil you with the food."

Each person in the home had a nutritional needs assessment using a recognised Malnutrition Universal Screening Tool (MUST). In addition to the service's assessment professional advice from dieticians and speech and language therapists had also been obtained, although this was not consistent. We saw one person's MUST assessment had been incorrectly calculated as only the most recent months weight loss had been referred to rather than that of the previous three to six months, as specified by the relevant guidance. Although the person remained within a healthy weight range, it was important that staff used the MUST tool in line with the guidance so potential concerns about unintended weight loss were not overlooked. The manager obtained a monthly overview of people's nutritional status. This highlighted potential concerns for six people, however we saw no further examination or follow up of these cases was evidenced. We undertook a more detailed follow-up of these people's associated records and found for those people still resident at the home appropriate follow-up action had been taken for one, two people's weight records had been completed incorrectly, a person with a low weight and body mass index (BMI), had not been weighed over the previous four months and for another person with a BMI of 17 there was no evidence of a referral

having been made to the GP or dietician. We were unable to review a fifth person's file, and the sixth person had since died. The kitchen staff had information on people's dietary on a large whiteboard. On the first day of our inspection we found that the whiteboard was not up to date although when we spoke with staff serving the food it was clear they were aware of people's needs. On the third day of the inspection the whiteboard correctly reflected people's needs. In addition the manager had ensured that information relating to people's nutritional and hydration needs had been updated within their written records of care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS applications had correctly been made to the local DoLS Authority. However DoLS that related to the covert use of medication were not being implemented correctly.

We recommended that the registered manager reviewed systems relating to the monitoring of the implementation of DoLS.

If people lacked capacity staff ensured that other professionals and family members were involved in order to support people in making decisions in their best interests. These best interest decisions were clearly recorded within people's files including who had been involved and how the decisions had been made in the person's best interests. The service was aware that some family members had lasting powers of attorney and ensured that these were acted upon in relation to making decisions about people's care or to update family members about a person's welfare. Lasting powers of attorney give families or guardians legal rights to be involved in either financial decisions or health and welfare decisions or both.

People we spoke with told us that they were always asked for their consent before staff supported them to do something. Staff told us that they would not provide any support without first asking for permission. Our observations confirmed this. Care plans in the home contained references to consent throughout.

Individuals' care records included guidance for staff about in what circumstances they should contact relevant health care services if an individual was unwell. We found evidence to show the majority of people who used the service were supported to access appropriate health care services, for example a visit from a GP. Asked about visits from healthcare professionals one person commented, "We do get nurses who come in, the chiropodist, hairdresser and a girl comes in and gives you a manicure."

Good

Is the service caring?

Our findings

We spoke with people and their relatives and asked them if staff treated them well. A relative said, "The majority of staff are excellent." A person who used the service told us, "The girls are very good … wonderful." And another added, "They take care of you." And another commented, "It's nice here."

We observed one person with complex care needs who required one to one support being cared for by staff. Staff were respectful of the person and made sure not to cause them further stress or anxiety. We noted that staff were working in a way that fully complied with the person's care plan.

When we spoke with staff they appeared to know people well. They were able to tell us about people's preferences and what kind of support they required. They were also able to tell us about people's histories and family connections. This showed that staff worked to build relationships with the people they supported.

We asked people and their relatives if they had been involved in the planning of their care. They told us that they had been involved in giving the service information about their likes' dislikes and their needs. People we spoke with told us they had not seen a final copy of their care plan. The care plans we looked at had not been signed by the people who they applied to. This meant people were not always actively involved in making decisions about their care, treatment and support.

We recommended the service reviewed the way it involved people in the planning of their care.

The service had policies in place that referred to upholding people's privacy and dignity. There were also policies relating to equality and diversity which helped to ensure people were not discriminated against. We saw staff knocking on people's doors before entering and asking permission to enter people's rooms. When we spoke with people who used the service they told us they felt that staff were mindful of their dignity and ensured when delivering any intervention, this was done in the way they wanted and preferred. However during our inspection we observed people being weighed in a communal area. This task could have been carried out in people's own rooms in order to maintain their confidentiality and dignity. We spoke with the registered provider and the registered manager about this. They agreed that it was inappropriate and spoke with the staff concerned.

The registered manager had details of local advocacy services that people could contact if they needed independent support to express their views or wishes about their lives. Advocates are people who are independent of the service and who can support people to make or express decisions about their lives and care. The manager described what they would do to ensure that individual wishes were met when this was expressed either through advocacy, by the person themselves or through feedback from relatives and friends.

The service had policies, procedures and training in place to support people who required end of life care. The service was able to offer support to people's families as well as to the person themselves. The service

worked alongside other providers to ensure that this care was carried out correctly.

When we spoke with people who used the service they told us that an important element of receiving support was to maintain their independence and that staff promoted this wherever possible. Care plans clearly identified the level of support that people required and gave staff clear instructions about how to promote independence. For example care plans around mobility clearly stated what people were able to manage independently and what support staff would be required to provide, for example ensuring people had access to their walking frame. One person told us, "They take care of you but it's a bit restricting. I walk with a [walking frame] the staff question where you are going."

Good

Is the service responsive?

Our findings

We spoke with people who used the service and their relatives, they told us they knew who to speak with if they had a comment or complaint about the service.

The service had a formal complaints policy and procedure. The procedure outlined what a person should expect if they made a complaint. There were clear guidelines as to how long it should take the service to respond to and resolve a complaint. The policy mentioned the use of advocates to help support people who found the process of making a complaint difficult. There was also a procedure to follow if the complainant was not satisfied with the outcome. The registered manager showed us a response to a recent and ongoing complaint. It included an apology and an action plan outlining what would be done to prevent further recurrence of the incident raised in the complaint. The registered manager explained that wherever possible they would attempt to resolve complaints informally.

When people were referred to the service an assessment of needs was carried out. This included assessing their mental wellbeing, their dietary needs and their mobility. The information was then used to write a care plan. This was then further developed and reviewed on a regular basis and as people's needs changed. Written records outlined the support that people required in all aspects of their life. For example one care plan outlined the support one person required to help them cope with anxiety and agitation. The care plan was very detailed and outlined exactly the interventions this person needed to assist them to remain calm and content.

The service was formulating clear and concise care plans that were easy to understand. Reviews of care plans were carried out regularly and involved the person receiving support or their relatives and health and social care professionals. The care plans gave clear instructions to staff about the support the person required and their preferences for how that should be delivered. Though some care plans we looked at had not been fully updated the majority contained correct and up to date information. The registered manager told us that all care plans were subject to an ongoing audit which was helping to ensure they were kept up to date. The care plans we looked at, particularly in the unit that cared for people who lived with dementia, confirmed this.

We saw evidence that confirmed that where possible people had been consulted with about their wishes and preferences as part of the process and this was in line with what staff delivered.

There was evidence within the care plans that showed people had exercised their choice. For example some people's care plans recorded their preferred choice for how they wished to spend their time. Other people were encouraged to make choices as part of maintaining their independence.

We asked people about their daily lives within the home. Some people told us they watched television or socialised with their friends. One person told us, "We have craft classes and bingo sometimes a film or entertainment. It's always someone's birthday and we have a party and they make you a nice cake." Staff often organised activities, we observed a dedicated activity co-ordinator making Christmas decorations with

people. A relative told us, "Mam loves a quiz!" The registered provider also hired local entertainers such as musical groups to come into the home and encouraged local schools to visit. Some people also took advantage of excursions that the provider arranged such as a trip to a local mining museum.

Where people were supported by more than one provider, the registered manager described how they liaised with both the other providers and the commissioners of the service to ensure that there were clear lines of communication and responsibility in place.

Good

Is the service well-led?

Our findings

The registered manager of Addison Court had only been in post for eight weeks on day one of our inspection. She was in the process of registering with the Care Quality Commission and by the third day had completed the application process and was awaiting an outcome. We noted that she was in the process of getting to know the people who lived at Addison Court and their relatives. Some people told us they were yet to meet her, others told us, "The new manager is the best thing they [the provider] have ever done, she cares."

We spoke with staff and asked them about their experience of the leadership within the service. They told us that the registered manager regularly came and spoke with them and 'walked the floor' checking on people's progress.

People and their relatives had received quality monitoring questionnaires to share their experiences with the registered provider. The replies of the questionnaires were constructive in nature. The manager used the information to help improve the service. For example, people in the most recent survey (February 2016) had raised that there were not sufficient activities within the home. Activity co-ordinators had undergone further training, particularly around activities for people who lived with dementia. Subsequently it was noted that activities had 'improved'.

The registered manager carried out checks on how the service was provided in areas such as care planning, staffing and health and safety. She was keen to identify areas where the service could be further improved. This included monitoring staff while they carried out their duties to check they were providing care safely and as detailed in people's care plans. This helped the manager to monitor the quality of the service provided. In the short period the registered manager had been in post she had identified several areas that required improvement, for example staff duty rostering.

At our last inspection in June 2016 breaches of legal requirements were found. We found audit and governance processes had failed to ensure satisfactory standards were maintained. Shortfalls identified in audits were not always addressed or improvement sustained. At that time we found audits and other quality checking systems were completed thoroughly, however there was evidence that the system did not always result in sustained improvements.

During this inspection we found that the service had improved the way they monitored quality improvement. However they had not acted on some of the outcomes of their own audits. For example the service had identified similar issues to the ones we highlighted in relation to medicines management but had failed to make significant short term improvements such as cleaning and tidying clinical areas and medicine cupboards. In addition, on the first day of our inspection, we examined a nutritional audit that identified people who were at risk of malnourishment but did not outline how these people were being kept safe. Though we found this information held in people's individual written records of care, the purpose of the audit was to alert the manager that people were at risk and inform them of how that risk was being reduced. When we checked this audit again on day three of our inspection we saw that the manager had

ensured that this information was now included. In addition, new audits had been devised to ensure other improvements had been made, such as ensuring pressure mattresses were correctly set.

We recommended that the provider continued to monitor its quality assurance systems in order to ensure improvements continued.

There were regular staff meetings held with members of staff so that important issues could be discussed and any updates could be shared. These were clearly recorded so that members of staff who were not able to attend could read them afterwards. We also saw that staff could visit the office and speak with senior staff whenever they needed to.

The manager had created links with local schools and was developing links with local churches, the police and other members of the community.

During the inspection the manager, the registered provider and senior staff were keen to work with us in an open and transparent way. All documentation we requested was produced for us promptly and was stored according to date protection guidelines.

The manager was aware of their duty to inform us of different incidents and we saw evidence that this had been done in line with the regulations. Records were kept of incidents, issues and complaints and these were all regularly reviewed by the registered manager in order to identify trends and specific issues.

We asked the manager about her vision for the home, she told us, "We are committed to providing the highest quality of care to all of our residents. The care, well-being, safety, and comfort of our residents is of paramount importance, with the aim of supporting them through person-centred care to achieve their optimum health so that they are able to live a good life. Our philosophy is based on our belief that every individual has the right to privacy, dignity and freedom of choice, and we actively encourage individuals to contribute to their personal care plans while ensuring respect, confidentiality, and sensitivity to their individual needs and abilities. We will provide stimulation through activities, and where appropriate, encourage independence to help our residents live as fulfilling a life as possible. Each member of staff in our homes will be highly trained to ensure that they develop the required skills and competences to enable them to fully support and care for our residents, and that their families benefit from the very best advice and expertise. This will support our staff to achieve high levels of job satisfaction, and ensure retention of staff and continuity of care for our residents. All of this will be underpinned by robust systems and processes, quality assurance audits, and committed and visible leadership."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment medicines were not managed appropriately.